Combined Intrauterine and Extrauterine Pregnancy

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COMBINED intrauterine and extrauterine pregnancy is rare. De Voe and Pratt[1] in 1948 were able to find only 395 cases reported in the literature to that date. In the case here reported there were confusing features which made early diagnosis difficult.

CASE REPORT

The patient, a pregnant white woman 32 years of age with two children, had vaginal bleeding for two days some four weeks after the last menstrual period. The episode was not associated with cramps or abdominal pain. Two months later, on March 3, the patient had lower abdominal cramps with vaginal spotting which progressively became more severe. She consulted a physician, who put her in hospital. A fetus 2 inches long was protruding from the open cervical os. It was removed and curettage was done on March 7. The patient was discharged the following day despite moderately severe abdominal cramps. During the next 24 hours the abdominal pain became increasingly severe and was associated with subcostal and left shoulder pains, especially on deep inspiration. Nausea, vomiting and chills developed.

When examined by me for the first time in the evening of March 9, the patient was obviously acutely ill. The pulse rate was 100, respirations 36 per minute, blood pressure 90/50 mm. of mercury and the temperature 98.8°F. The skin was pale and dry. The patient said she had decided pain in the shoulders on inspiration. The lungs were clear to auscultation and percussion. Movements of the diaphragm was less than normal. The heart was normal in all respects. The abdomen was distended, with tenderness general but more pronounced in both lower quadrants. There was rebound tenderness, but no point tenderness, and bowel sounds were normal. A well-healed appendectomy scar was noted. Upon pelvic examination, decided bilateral adnexal tenderness was observed. There was no bulging of the cul-de-sac. The uterus could not be outlined because of pain. No bleeding was noted.

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It was felt that the patient had peritonitis secondary to a perforation of the uterus at the time of previous dilatation and curettage. She was put in the hospital. The hemoglobin content of the blood was 8.0 gm. per 100 cc. Leukocytes numbered 13,000 per cu. mm. with a shift to the left in the cell differential. No abnormality was noted in the urine. Roentgenographic examination of the abdomen did not reveal free air under the diaphragm. For medico-legal reasons a surgical consultant examined the patient. He concurred with the diagnosis.

The patient was given blood, intravenous fluids and antibiotics (streptomycin and penicillin) and was placed in Fowler's position. In the next few hours the patient's general condition improved and it was felt that surgical intervention was not indicated. By the next day the patient was considerably more comfortable. The respiratory rate was slower and the shoulder pain and abdominal distention were diminished. The abdominal tenderness was less but there was some suggestion of localization in the left lower quadrant. The patient was able to tolerate oral feedings, voided and had a spontaneous bowel movement. On March 13 a low-grade spiking temperature developed. On March 14 the hemoglobin content was 9.9 gm. per 100 cc. Erythrocytes numbered 3,120,000 per cu. mm. and leukocytes 7,000 per cu. mm. with a differential within normal limits. The sedimentation rate was 45 mm. in one hour (corrected).

Although the patient felt well in general, considerable tenderness continued in the left lower quadrant of the abdomen. Pelvic examination could not be carried out satisfactorily because the patient complained of too much pain on bimanual manipulation. Since it was felt that a pelvic abscess probably was developing, spot x-ray films were made over the left lower quadrant. No abnormality was shown in them.

The patient was discharged on March 18 with the admonition that she probably would need readmission later for drainage of an abscess. She was given a prescription of oxytetracylin by mouth for one week. When the patient was next observed in the office on March 31 she still had discomfort in the left lower quadrant of the abdomen. There were no other complaints. The temperature was 98°F., the pulse rate 80 and blood pressure 120/70 mm. of mercury. There was considerable left lower abdominal tenderness on pressure and on rebound. Upon pelvic exam-

ination it was noted the cervix pointed posteriorly and the uterus was slightly enlarged and pushed to the right. The cervix and the uterus were tender to motion. No abnormality was noted in the right adnexa, but there was decided tenderness on the left side with a questionable 6 x 6 cm. mass palpable high in the left fornix. No cul-de-sac bulging was present. Dark blood oozed from the external os. A left ectopic pregnancy was considered the most likely diagnosis. A Friedman test was carried out and the result was reported as positive in 48 hours. Since it had been 17 days since the dilatation and curettage for incomplete abortion, it was felt that the test indicated additional extrauterine gestation.

The patient was readmitted to the hospital and on March 24 an exploratory laparotomy was done. A ruptured left tubal pregnancy was found and there was about 300 cc. of fresh and old blood in the peritoneal cavity. A left salpingo-oophorectomy was performed uneventfully. The patient tolerated the procedure well and the immediate postoperative course was uneventful. She was ambulatory in 24 hours, tolerated oral feedings and on the second postoperative day started to pass flatus. Sutures were removed on the sixth postoperative day and the patient was discharged March 31. That evening she complained of nausea and of being unable to keep anything on her stomach. No abnormality was observed on physical examination, however, and it was felt that the difficulty was probably of an emotional nature. But the patient's condition did not improve and on April 2, 36 hours after onset of nausea and vomiting, she began to complain of colicky abdominal pains. There had been no bowel movements or passage of flatus during the preceding 12 hours. The blood pressure was 120/70 mm. of mercury, the pulse rate 70 and the temperature 98.0°F. Slight abdominal distention was present and there was an ill-defined mass thought to be a loop of intestine palpable in the left upper quadrant. Borborygmi were heard. The patient was readmitted to the hospital with a diagnosis of mechanical intestinal obstruction. X-ray films of the abdomen and surgical consultation confirmed the impression. In an attempt to decompress the bowel, a Harris tube with mercury was introduced but it remained curled up in the stomach. The patient was carefully observed for the next 12 hours, and since no improvement was observed, exploratory laparotomy was carried out. An obstruction high in the small bowel due to kinking and adhesions was observed and was relieved easily after lysis of adhesions.

The postoperative course was entirely uneventful. Gastric suction and parenteral feedings were maintained for three days, at which time peristalsis returned to normal and the patient passed flatus. Oral feedings were begun then and were tolerated well. Retention sutures were removed on the sixth postoperative day and all other sutures on the eighth postoperative day. Patient was discharged, feeling well.

SUMMARY

A case of combined intrauterine and extrauterine gestation is presented with the complicating features of possible uterine perforation and postoperative mechanical intestinal obstruction, necessitating laparotomy.

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REFERENCE

1. DeVoe, R. W., and Pratt, J. H.: Simultaneous intrauterine and extrauterine pregnancy, Am. J. Ob. & Gyn., 56:1119-1125, Dec. 1948.

Acute Renal Tubular Failure

A Report of 2 Cases with an Unusual Mechanism Of Poisoning Due to Sodium Chlorate

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ALTHOUGH poisoning with sodium chlorate or other like compounds is not unusual, the following cases are reported because of the rather unique mechanism of poisoning.

CASE 1. A 29-year-old Negro laborer, an employee of a trucking firm, was first seen on December 12, 1955. After spending an hour inside a large aluminum tank truck, cleaning the tank, he noted the onset of severe weakness, generalized numbness, headache, nausea, dizziness and excessive salivation. He climbed out of the tank and soon began to have severe cramping abdominal pains, chills, fever, pains in all four extremities and paresthesias of the hands and feet, and then vomited several times. The tank which he had been cleaning had recently been used to deliver a liquid mixture of 18.2 per cent sodium chlorate and 10 per cent sodium metaborate which is used by the Highway Department to destroy roadside weeds.

When examined the patient was acutely ill, dyspneic and cyanotic. He complained of generalized pains and chilliness. The blood pressure was 160 mm. of mercury systolic and 60 diastolic. The temperature was 102.2°F., the pulse rate 100 and respirations 28 per minute. Diffuse injection of the conjunctivae was noted. The pupils were in the midposition and reacted to light and accommodation. No abnormality was observed in the ocular fundi. The tympanic membranes were rather dull and injected. The mouth and throat were normal. There was a well-healed scar in the right lower anterior chest from a previous accidental gunshot wound some five years earlier. No abnormalities were noted in the heart or lungs. The abdomen was rounded, soft and diffusely tender. The liver and spleen were not palpable. Rectal examination showed no abnormality. There was extreme weakness of all extremi-

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